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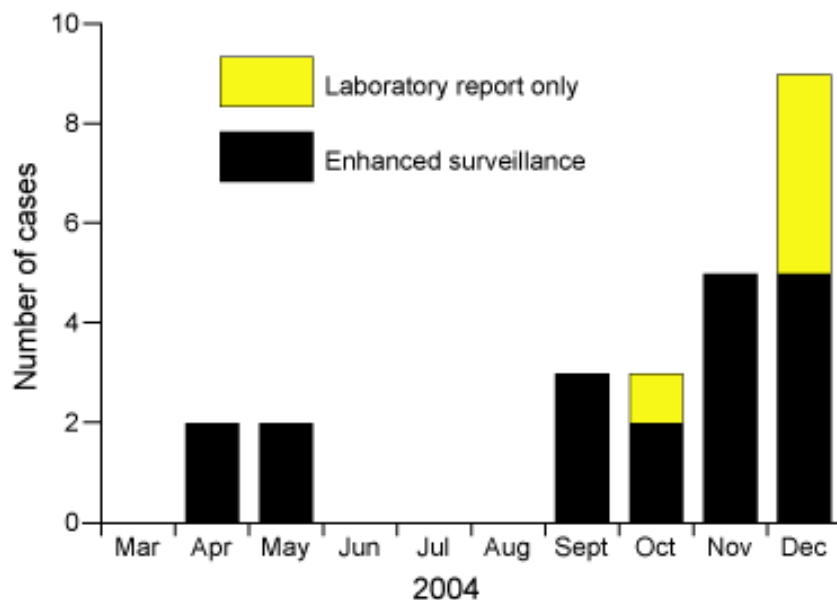
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Initial results of enhanced surveillance for lymphogranuloma venereum (LGV) in England

Following the launch of an initiative to raise awareness and improve the diagnosis and surveillance of lymphogranuloma venereum (LGV) in England in October 2004 (1), the Health Protection Agency (HPA) has confirmed 24 cases of LGV using genotypic methods from chlamydia specimens submitted to its Sexually Transmitted Bacterial Reference Laboratory (see figure). All of the cases are of the L2 serovar.

Figure Number of laboratory confirmed cases of LGV and enhanced surveillance reports up to 26 January 2005



Enhanced surveillance follow-up of confirmed cases through clinicians has provided additional information on 19 of the 24 patients to date. All 19 were homosexual men with a median age of 40 years (range 24 to 52 years). Seventeen (89%) were HIV positive. Most were referred or presented to genitourinary medicine/HIV clinics with symptoms suggestive of LGV. Anorectal symptoms (typically rectal pain, discharge, and bloody stools) were reported for 18 patients. Systemic symptoms (typically general malaise) were reported for 7 patients. Two had inguinal LGV symptoms (swollen/painful lymph nodes in the groin). Concurrent sexually transmitted infections were reported for 8 (42%) patients (warts, gonorrhoea, herpes, and non-specific urethritis). Four (21%) were hepatitis C antibody positive. Ten of the 15 men for whom probable country of LGV infection was reported are thought to have acquired their infection in the United Kingdom (UK), with countries in mainland Europe reported for the remaining five (the Netherlands, Spain two each, Germany, and Italy one). Unprotected anal intercourse in the three months prior to LGV symptoms was reported for 13 men, four of whom were reported to have engaged in unprotected fisting (insertive and receptive) as well. The use of unprotected sex toys was reported for two men. The majority of patients were treated with a 21-day course of doxycycline antibiotic.

Although the majority of cases have been reported from London, others have been identified from other cities across the UK. From the laboratory confirmed cases and probable retrospective cases, for whom genotypic confirmation has not been possible, it appears likely that LGV infection may have been present in homosexual men in the UK since at least the beginning of 2004. The recent increase in cases may in part reflect increased awareness among clinicians and microbiologists following the HPA's alert in October 2004 (1), as well as increased awareness among gay men following a publicity campaign conducted by the Terrence Higgins Trust's Gay Men's Health Promotion Team. This included a leaflet targeted at men of increased risk and a sector briefing that featured widely in the Gay press in December. These materials are available on request from the Terrence Higgins Trust by email, <info@tht.org.uk>.

The HPA is currently in the process of convening an incident team in response to these findings.

Lymphogranuloma venereum (LGV) is a sexually transmitted disease caused by a specific type of *Chlamydia trachomatis* (serovars L1, L2, and L3). Unlike other forms of *C. trachomatis*, LGV is invasive and affects the lymphatic system. The symptoms of LGV vary according to the site of infection and may include inflamed and swollen lymph nodes in the groin (inguinal syndrome) and acute hemorrhagic proctitis (anorectal syndrome). If left untreated, the symptoms can become more severe and cause lasting damage to health.

Further information, including the LGV enhanced surveillance protocol, can be found on the HPA website at: <http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/LGV/lgv.htm>.

1. HPA. Enhanced surveillance of Lymphogranuloma Venereum (LGV) in England. *Commun Dis Rep CDR Wkly* [serial online] 2004 [cited 20 January 2005];14(41): News. Available at <<http://www.hpa.org.uk/cdr/PDFfiles/2004/cdr4104.pdf>>.

Surveillance of significant occupational exposure to bloodborne viruses in healthcare workers: 1 July 1996 to 30 June 2004

The Health Protection Agency's Centre for Infections (CFI) has this week published Eye of the Needle, the latest report from the surveillance of significant occupational exposure to bloodborne viruses (BBVs) in healthcare workers (HCWs) (1). This report includes significant occupational exposure incidents reported to the CFI between 1 July 1996 and 30 June 2004 from reporting centres. There are currently 150 reporting centres scattered throughout England, Wales, and Northern Ireland.

There have been nine reported hepatitis C (HCV) seroconversions in HCWs following occupational exposures to HCV positive source patients. Six of these transmissions were reported between July 2003 and June 2004 including three within the first two months of 2004. Six of the seroconversions involved source patients who were male injecting drug users (IDUs). All seroconversion cases followed percutaneous exposures mostly to fresh blood from hollowbore needles, with moderate to deep injuries. Of the nine seroconversions, six are known to have occurred after the procedure that the HCW was undertaking. Five of would not have occurred if procedures for the safe handling and disposal of sharps and clinical waste had been followed. The HCV seroconversion rate for four of the cases exposed to a positive HCV source patient and where complete follow-up information was available for the denominator, cases reported at the same time period as the seroconversions but HCV negative at six months follow-up, was 1.5% (4/264). There is currently no post-exposure prophylaxis (PEP) or vaccine for HCV that will prevent transmission, although appropriate follow-up and support is vital in these exposure cases, since, in those infected, early referral and treatment with combination therapy, pegylated interferon, and ribivirin has been show to be effective in reducing the risk of progression to chronic HCV infection, and in most cases leads to viral clearance. Of the nine reported HCV infections, one case cleared the virus spontaneously, another is still receiving treatment, and the rest have successfully cleared their infection following treatment.

Findings in the report indicate that there are still a number of follow-up reports that have incomplete information, particularly in relation to post-exposure testing, and post-exposure tests being done inappropriately. Where HCWs did not receive any further follow-up at a local level, they remain unaware of the outcome of their BBV exposure and some may have been infected.

One report of HIV seroconversion in a HCW following occupational exposure was received (2) giving an HIV seroconversion rate of 0.8% (1/122). The overall internationally observed seroconversion rate is lower. The reported seroconversion rate in the surveillance programme maybe an overestimate, due to incomplete denominator data, as six month post-exposure testing for HIV exposures is poorly reported. Findings from the surveillance programme, indicate that most HCWs exposed to the risk of HIV infection were commenced on HIV PEP within 24 hours of exposure. National guidance states that HCWs should be started on HIV PEP as soon as possible after the exposure, ideally within an hour (3).

Percutaneous injury was the most commonly reported type of exposure (78%; 1664/2140), mainly involving hollowbore needles (63%; 1056/1664). Mucocutaneous exposures accounted for 22% (461/2140) of initial reports received. Injuries in nursing-related professionals represented 45% (962/2140) of the initial reports with medical professions (including doctors and dentists) accounting for 37% (793/2140). Overall, a larger proportion of doctors reported occupational exposures to BBVs. Two per cent (39/2140) of reports concerned exposures to ancillary staff, who do not offer direct patient clinical care. Their injuries were mainly as a result of non-compliance with universal precautions by other members of staff.

Seventy-eight per cent (1244/1597) of six week follow-up reports received were on exposures that occurred in a ward, theatre, and intensive care and accident and emergency departments. Where reported, 37% (588/1597) of exposures occurred after the procedure had been performed, but before disposal of the device, and during or after disposal. These incidents are predominately related to failure to comply with procedures for the safe handling and disposal of sharps and clinical waste, and were mostly preventable.

National guidance recommends the use of universal precautions in order to protect HCWs from exposure to BBVs (4). In addition to safe handling and disposal of sharps and clinical waste, incidents can be avoided by simple precautions such as not resheathing needles and not manually disassembling disposable devices. Trusts should have protocols in place for the management of HCWs who have sustained an occupational exposure, and primary care trusts working with both hospitals and local health protection units should ensure that arrangements are in place for managing exposures occurring in HCWs outside the hospital environment. Microbiologists and Virologists working with occupational health, infectious disease, and genitourinary medicine colleagues are encouraged to ensure that appropriate and timely testing and follow-up arrangements are available and consistent with national guidance.

Incidents of HCWs occupationally exposed to BBVs in England, Wales, and Northern Ireland, should be reported to Jane Aston/Sarah Tomkins at the HPA Centre for Infections (tel: 020 8327 7152/7095).

1. Health Protection Agency, National Public Health Service for Wales, CDSC Northern Ireland. *Eye of the Needle. Surveillance of significant occupational exposure to bloodborne viruses in healthcare workers –seven-year report*. London: Health Protection Agency, January 2005. Available at: <http://www.hpa.org.uk/infections/topics_az/bbv/bbmenu.htm>.
2. Heptonstall J, Gill ON, Porter K, Black MB, Gilbert VL. Health care workers and HIV: surveillance of occupationally acquired infection in the United Kingdom. *Commun Dis Rep CDR Rev* 1993; 3: R147-53. Available at <<http://www.hpa.org.uk/cdr/CDRreview/1993/cdr1193.pdf>>.
3. Department of Health. *HIV Post-Exposure Prophylaxis: Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS*. London: Department of Health, February 2004.
4. Expert Advisory Group on AIDS and the Advisory Group on Hepatitis. *Guidance for clinical health care workers: protection against infection with bloodborne viruses*. London: UK Health Departments, 1998.

Further human cases of avian influenza (H5N1) in Viet Nam – 26 January 2005

On 26 January, the World Health Organization (WHO) issued a statement confirming two further laboratory confirmed cases of human infection with influenza A (H5N1) in Viet Nam.

The first case, who died on 21 January after developing symptoms on 14 January, was a 35 year old woman from the southern province of Dong Thap. The second case was a 17 year old boy from the southern province of Bac Lieu who died on 10 January after developing symptoms on 14 January.

On 21 January, WHO reported a family cluster from Thai Binh province in northern Viet Nam. Influenza A (H5N1) was detected from samples collected from two family members: a 46 year old, who died on 9 January 2005 after developing symptoms on 1 January and his 42 year old brother, now fully recovered, who was hospitalised in Hanoi after developing symptoms on 12 January. Their younger brother, aged 36 years, who was hospitalised for observation, did not develop symptoms.

Two possible modes of infection are being considered by the health authorities in Viet Nam who are currently investigating these cases. The first is that the 42 year old who provided bedside care for the deceased man may have acquired his infection directly from his brother. The second is that the infection may have been linked to a family meal in which a dish containing raw duck blood and raw organs was served.

WHO states that isolated but unsustained ('dead end') cases of human-to-human transmission can be expected from avian influenza viruses in humans, but that their occurrence does not call for any change in the present level of pandemic alert. One such probable transmission has recently been reported from Thailand (1). Equally, the consumption of dishes made with fresh duck blood or with raw or inadequately cooked poultry products has been repeatedly advised against by public health officials in Viet Nam.

The Health Protection Agency advice regarding the consumption of poultry in affected parts of south east Asia remains that while there is no confirmed evidence of acquiring influenza A (H5N1) infection through the consumption of infected poultry it is considered a sensible precaution to ensure that poultry is properly cooked in accordance with WHO recommendations.

Since mid-December 2004 ten cases of influenza A (H5N1) have been identified in Viet Nam, of which eight have died. Since January 2004, 54 human cases of avian influenza have been reported in Asia, of which 41 have been fatal.

Further information is available from WHO at <http://www.who.int/csr/disease/avian_influenza/en/>.

WHO advice about the consumption of poultry in affected areas is available at <<http://www.who.int/foodsafety/micro/avian/en/>>.

1. Ungchusak K, Auewarakul P, Dowell SF, Kitphati R, Auwanit W, Puthavathana P, et al. Probable person-to-person transmission of avian influenza A (H5N1). *New Eng J Med* 2005 ; **352**: 333-40. Abstract available online at <<http://content.nejm.org/cgi/content/short/352/4/333>>

South Asian Tsunami – situation update

Since the tsunamis struck several countries in south Asia and east Africa on 26 December 2004, following an earthquake off the coast of Sumatra, a massive global relief effort has been underway to help the countries involved come to terms with the devastating effects of the flooding.

The countries that were most affected were India, Indonesia, Malaysia, Maldives, Myanmar, Sri Lanka, Thailand, and Somalia. In these countries so far, there have been over 214,000 deaths, with over 20,000 people still missing and over 1.5 million people who have lost their homes (1). Fifty-three people from the United Kingdom are known to have died, as of 24 January 2005. Most were in Thailand, and another 480 people, who were known or thought to be in affected areas when the tsunamis struck, are still missing (2).

As a result of the extensive damage to infrastructures, overcrowding due to displaced people staying in relief camps, and annual rains in some areas, the threat of water-borne and vector-borne diseases is a concern and the World Health Organization, together with international aid agencies are working to make sure that disease surveillance is a high priority (3). There have been no major disease outbreaks reported in tsunami-affected regions as of 25 January 2004, and early warning systems are in place in all affected areas. There have, however, been sporadic cases of infections, which are summarised in the table below.

Country and last update	Areas affected	Situation update
India (4) 23/01/05	Andaman and Nicobar (A&N) Is, states of Tamil Nadu, Andhra Pradesh, Kerala, and Union Territory of Pondicherry	Over 10,000 deaths, 647,556 people displaced, 5551 missing from A&N Is. Water supply has been restored in most affected areas, but sanitation needs to be improved in many relief camps. No reports of outbreaks of communicable disease have been reported. Disease surveillance units have been set up on the mainland.
Indonesia (5) 23/01/05	Northern and western parts of the island of Sumatra, particularly the province of Aceh	166,760 deaths, 452,845 people displaced, 6222 missing. Two new field hospitals are operational. WHO and UNICEF will provide support for an assessment of health, water and sanitation in 50 priority camps in Banda Aceh, starting on 24 January 2005. Communicable diseases reported: two suspected cases of melioidosis are being investigated, 91 reported cases of tetanus including 11 deaths, 11 cases of shigellosis, one suspected case of dengue fever. No potential epidemics reported as of 23 January. 25,000 children have been vaccinated against measles.
Malaysia (6) 17/01/05	NW coast, particularly Penang, Kedah, Perlis, Perak.	68 deaths, 8000 displaced, six missing. No outbreaks of communicable diseases have been reported.
Maldives (7,8) 22/01/05	All 20 atolls affected	82 deaths, 10578 people displaced, 26 missing. A total of 86 islands lack drinking water and 33 islands lack electricity. Of 87 resorts, 19 were severely damaged and had to be closed down, while 14 others have suffered major partial damages. No disease outbreaks reported although 680 cases of diarrhoea, ten acute respiratory infections, 86 viral fevers and four cases of fever with vomiting have been reported throughout the islands including Male.
Myanmar (9) 20/01/05	12 townships in Ayeyawaddy, Tanintharyi, Yangon divisions, and Rakkhine state.	61 deaths, three missing; fishermen have been the worst affected. No outbreaks of disease have been reported although there is a potential risk of malaria epidemics in coastal areas. Extra antimalarial drugs have been shipped.
Somalia (1) 23/01/05	Hafun peninsular, Bender Beyla, Baargaal and Eyl, regional state of Puntland	Approximately 150 deaths and 4000 displaced. Fishermen largely affected. No outbreaks of communicable disease reported although little information currently available.
Sri Lanka (10) 23/01/05	13 districts in the southern and eastern coastal areas. Ampara, Hambantota, Trincolamee, Batticaloa and Galle were the most affected.	30955 deaths, 403,245 displaced, 5637 missing. Approximately half of displaced people are living in camps and half with relatives. There is a shortage of water in some camps. No major outbreaks of communicable diseases reported, although the main cause of morbidity in Batticaloa is acute respiratory infection.
Thailand (11)	South western and coastal areas, including Phi Phi, Krabi, Phuket, Phang Nga, Ranong, Trang, Satun	5374 dead, 1/3 Thai, 1/3 foreign, 1/3 unknown; 3132 missing. No major communicable disease outbreaks reported, although as of 22 January 2005, there have been 3685 cases of disease including five deaths reported. Diseases include sporadic cases of diarrhoea, pneumonia, influenza, dengue fever and wound infections.

World Health Organization teams, including personnel from the United Kingdom, are being deployed to the region under Global Alert and Response arrangements (GOARN) to help detect and mitigate the impact of infection. Those who live in or are travelling to tsunami-affected areas are likely to be at increased risk of infection from the following illnesses: intestinal illness such as salmonellosis, typhoid, campylobacteriosis, shigellosis, and cholera; mosquito transmitted diseases including malaria and dengue; and other diseases such as leptospirosis, diphtheria, and skin, eye, and ear infections. Advice for those intending to travel to tsunami-affected regions has been published by the National Travel Health Network and Centre at http://www.nathnac.org/travellers/tsunamis_asia.html and remains current. Information for health professionals and for those returning from affected areas is available on the HPA website at http://www.hpa.org.uk/infections/topics_az/travel/current_items/tsunami_adv.htm.

Current updates on the situation in specific countries is also available from the World Health Organization at http://www.who.int/hac/crises/international/asia_tsunami/sitrep/en/ and the Foreign and Commonwealth Office at <http://www.fco.gov.uk/servlet/Front?pagename=OpenMarket/Xcelerate/ShowPage&c=Page&cid=1007029390590>.

1. World Health Organization. South Asia Tsunami Situation Update No 25. 23 January 2004. Available online at http://www.who.int/hac/crises/international/asia_tsunami/sitrep/25/en/
2. Foreign and Commonwealth Office. South east Asia tsunami update. Available online at <http://www.fco.gov.uk/servlet/Front?pagename=OpenMarket/Xcelerate/ShowPage&c=Page&cid=1022686957237>
3. World Health Organization. South Asia Tsunami Situation Update No 26. 24 January 2004. Available online at http://www.who.int/hac/crises/international/asia_tsunami/sitrep/26/en/
4. World Health Organization, Regional Office for South East Asia (SEARO). India Tsunami Situation Report 23 January 2005. Available at http://w3.whosea.org/en/Section23/Section1108/Section1835/Section1851/Section1866_8599.htm
5. World Health Organization, Regional Office for South East Asia (SEARO). Indonesia Tsunami Situation Report 23 January 2005. Available at http://w3.whosea.org/en/Section23/Section1108/Section1835/Section1851/Section1867_8598.htm
6. World Health Organization, Western Pacific Region. Daily report: Malaysia Tsunami Disaster. Available at http://www.wpro.who.int/themes_focuses/theme3/special/docs/tsunamis/DailyReport_17Jan05.doc
7. World Health Organization, Regional Office for South East Asia (SEARO). Maldives Tsunami Situation Report 22 January 2005. Available at http://w3.whosea.org/en/Section23/Section1108/Section1835/Section1851/Section1868_8597.htm

Immunisation

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Next update due: 24 February 2005

[Laboratory reports of invasive meningococcal infections, England and Wales: weeks 35-39/2004](#)

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Laboratory reports of invasive meningococcal infections, England and Wales: weeks 35-39/2004

	Method of diagnosis			Total reports	Cumulative*
	CSF and blood Culture	Non-culture	Other sites	35-39/04	Total to week 39/2004
Group A	1	1	–	2	3
B	23	28	3	54	820
C	2	1	–	3	47
W135	–	–	–	–	28
X	–	–	–	–	–
Y	–	–	–	–	19
Z	–	–	–	–	–
29E	–	–	–	–	–
Ungroupable	–	–	–	–	–
Ungrouped	–	9	–	9	34
Total	26	39	3	68	952

* Combined CDSC data and Meningococcal Reference Unit data latex antigen, microscopy, polymerase chain reaction.

Laboratory reports of hepatitis A, England and Wales: July to September 2004



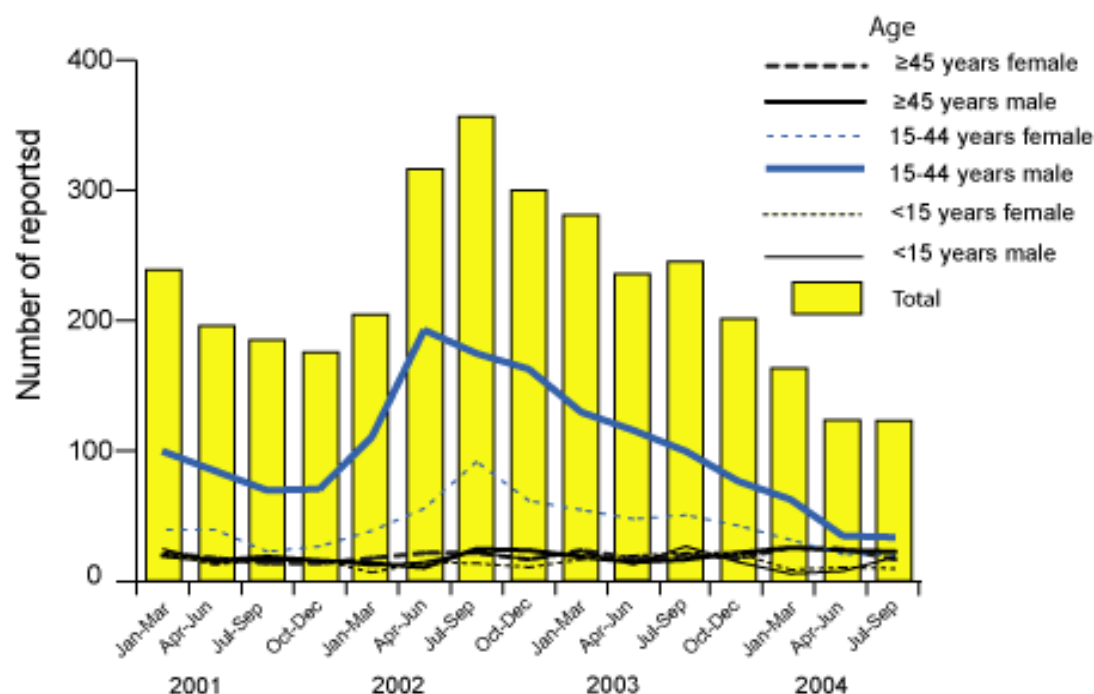
During the third quarter of 2004, 131 laboratory reports of hepatitis A were made to the Health Protection Agency Communicable Disease Surveillance Centre (CDSC), 46% (114) less than in the equivalent quarter of 2003. Encouragingly, the last six quarters have seen a decrease in the number of cases compared to the equivalent quarters in the previous year. Twenty-six per cent of cases (34) were men aged 15 to 44 years (table 1) and the majority of cases occurred in the North West region. Two people acquired their infection abroad (Pakistan and Egypt, one each) and no infections were reported to be in injecting drug users (IDUs). The overall number of cases of hepatitis A in the third quarter of 2004 increased by 5% (6), compared to that of the second quarter of 2004. Decreases in the number of cases were seen across all age groups for both males and females, with the exception of males under 15 years of age, where a substantial increase (58%) was observed. It is too early to be able to assess whether this is a real increase or not. Although there has been a slight overall increase in the total number of laboratory reports this quarter compared to last, the general declining trend seen following the 2002 outbreak year is still evident when figures are compared to the same quarter in the previous year (figure 1).

Table Laboratory reports of acute hepatitis A infection by age group and sex, England and Wales: July to September 2004*

Age group (years)	Male	Female	NK	Total
01-04	3	1	2	6
05-09	6	4	1	11
10-14	10	5	1	16
15-24	13	8	1	22
25-34	13	8	1	22
35-44	8	4	–	12
45-54	9	5	–	14
55-64	8	3	–	11
≥ 65	6	9	–	15
Not known	–	1	1	2
Total	76	48	7	131

*all data are provisional

Figure Number of laboratory reports of hepatitis A by age group and sex: January 2001 - September 2004



Under-reporting and variations in regional reporting continue to present a challenge. A total of 160 cases of hepatitis A were formally notified in the third quarter of 2004, 18% more than laboratory confirmed. The number of notifications exceeded the number of laboratory reports for four English regions plus Wales, while the number of laboratory reports exceeded the number of notifications for the other five English regions. Discrepancy between notifications and laboratory reports was highest in East of England and the South East. In the former, ten laboratory reports were made while only six cases were formally notified and in the latter twenty-nine cases were formally notified while only ten laboratory reports were made. Discrepancies continued to be high in London where forty-two cases were formally notified and only eighteen laboratory reports were made.

Although the total number of laboratory reports increased this quarter compared to last, the number of notifications has decreased. This decrease in notifications, combined with the facts that not one case was reported in a known IDU and Yorkshire and the Humber was no longer the region with the highest number of cases, suggests that the outbreaks that occurred in the IDU community have been successfully controlled.

Priorities for improving control of hepatitis A include enhancing risk factor reporting by clinicians to laboratories and from laboratories to CDSC, increasing the speed and rates of notification of cases by clinicians to Health Protection Units, obtaining greater participation in laboratory reporting of cases, and providing better detection and definition of outbreaks through means such as the application of hepatitis A virus genotyping.

Laboratory reports of acute hepatitis B infection by age group and sex, England and Wales: July to September 2004*

Age group (years)	Male	Female	NK	Total
<1	–	–	–	–
01-04	1	–	–	1
05-09	–	–	–	–
10-14	1	–	–	1
15-24	12	11	–	23
25-34	16	9	1	26
35-44	16	4	–	20
45-54	6	5	1	12
55-64	6	3	–	9
≥65	2	–	–	2
Total	60	32	2	94

* all data are provisional

Laboratory reports of hepatitis C infection by age group and sex, England and Wales: July to September 2004*

Age group (years)	Male	Female	NK	Total
<1	–	–	–	–
01-04	6	8	1	15
05-09	2	1	–	3
10-14	2	2	1	5
15-24	127	73	4	204
25-34	403	237	15	655
35-44	418	146	12	576
45-54	195	76	4	275
55-64	46	40	5	91
≥65	32	35	5	72
NK	19	4	2	25
Total	1250	622	49	1921

* all data are provisional